

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FROM ANOTHER FACILITY

PATIENT NAME:		Birth Date:	SS No. (optional)	
		Other Names Known By:		
Person/Organization Authorized to Disclose Protected Health Information:				
Release Records To: The Cardiovascular clinic of west TN Attention: _____		Address: 162 Murray Guard Dr		City: Jackson
		Telephone #: 731-256-1819 Fax #: 731-664-4330		State: TN Zip: 38305
Purpose of Disclosure: <input type="checkbox"/> Medical Care <input type="checkbox"/> Insurance <input type="checkbox"/> At the Request of the Patient <input type="checkbox"/> Media, Public Relations, Marketing, Advertising, Posting, or Radio Broadcasting <input type="checkbox"/> Other, Please Explain:				
Description of Information to be Used or Disclosed:				
Dates of Treatment:		Place of Treatment:		
Choose From the Following:				
<input type="checkbox"/> All Dictated Reports	<input type="checkbox"/> Lab (may include AIDS/HIV information)	<input type="checkbox"/> History & Physical		
<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Pertinent Summary	<input type="checkbox"/> Pathology Reports		
<input type="checkbox"/> ER Record	<input type="checkbox"/> Consultation	<input type="checkbox"/> Discharge Summary		
<input type="checkbox"/> Operative/Procedure Report	<input type="checkbox"/> Entire Chart	<input type="checkbox"/> Anesthesia Record		
		<input type="checkbox"/> Photographs/Images		
		<input type="checkbox"/> Billing Record		
		<input type="checkbox"/> Other (specify):		
I understand that:				
<ol style="list-style-type: none"> 1. I may revoke this authorization in writing at any time by notifying in writing the person/organization providing or disclosing the information. However, if I revoke this authorization, it will not have any effect on any actions taken by the person/organization providing, disclosing, or receiving the information prior to receiving the revocation, nor shall it be valid to the extent that the disclosing person/organization or receiving organization has taken action in reliance on this authorization. 2. This authorization allows The Cardiovascular clinic of west TN to obtain any and all documents in my medical record including those copies from other health care facilities and providers. I understand that the information that is released or provided may be re-disclosed and no longer protected by federal privacy regulations. 3. Any disclosure of records concerning diagnosis and/or treatment of alcohol and/or drug abuse is covered by Title 42 CFR, and if there is any such information, I hereby authorize the release of information. This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus. 4. The Cardiovascular clinic of west TN is hereby released from any liability and the undersigned will hold The Cardiovascular clinic of west TN harmless for requesting or seeking my protected health information. 5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal will affect my ability to obtain treatment, receive payment, or eligibility for benefits. 6. The authorization will expire in ninety (90) days unless I provide an alternate date or event. This authorization will not apply to any dates of service that occur after the date this authorization is signed. 7. A facsimile of this authorization or a copy of this authorization shall be valid and binding with the same force as an original signature, and the person/organization releasing the information shall be entitled to rely on the same. 				
I have read and understood this authorization. I hereby authorize the release of the above-requested medical information about me to The Cardiovascular clinic of west TN from the facility named above.				
_____ Signature of Patient		_____ Signature of Patient's Authorized Representative		
_____ Telephone Number	_____ Date	_____ Description of Representative's Authority to Act for Patient		